GENERAL INFORMATION:

This Excel file consists of 2 worksheets. Each worksheet is labeled as to its function.

If you are unable to see the tab for the worksheet across the bottom of the screen, click on the maximize button (the center button) located in the upper right-hand corner of the worksheet.

The worksheet is protected to prevent the changing of formulas and formatting features built into the spreadsheets.

You may submit completed forms in an electronic format or printed format. You must ensure that consumer information is protected as required by State and Federal law.

FOR ELECTRONIC FORMATS ONLY: If you submit this form to the regional center as an email attachment or on a CD ROM use the following naming standard: Each file must start with the designation of "B" followed by the provider's three digit numerical designation and the month and year. See chart for month designations. For example: B372-JA04 is Form DS 1961 WAP for provider ID# 372 for January 2004.

FOR ELECTRONIC FORMATS ONLY: This form contains information protected under the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164). ***The file must be password protected*** to ensure the safety of the consumer's information. Coordinate with the regional center regarding protecting the consumer information contained in this form.

PROVIDER INSTRUCTIONS:

Provider Information

Provider Name: Enter the name of the agency as vendored by the regional center.

Provider Number: Enter the agency's number provided by the vendoring regional center.

Check whether the report is the Initial report, an Annual report, or a Semi-Annual report.

Date: Enter the date the report is completed. Enter date as mm/dd/yy.

Address/City/ZIP: Enter the provider's business address, city, and ZIP code. The business street address should be the address the provider uses to conduct all its business activities. If the provider's business address is outside of California, list the two letter state abbreviation in the city field.

Phone: Enter the telephone number, including area code, of the provider. Enter telephone number as XXX XXX-XXXX.

Work Activity Program Consumer Information

Last Name: Enter the consumer's last name.

First Name: Enter the consumer's first name.

UCI: Enter the consumer's seven digit UCI #. If the UCI # entered is less than or more than 7 digits, the field will remain light orange.

SSN: Enter the consumer's nine digit SSN#. If the SSN # entered is less than or more than 9 digits, the field will remain light orange.

Semi-Annual Objectives and Progress

Productivity Rate: Enter the percentage of consumer's productivity each six month period. Enter the consumer's goal and the actual percentage during each period of the program.

Attendance Level: Enter the percentage of consumer's attendance each six month period. Enter the consumer's goal and the actual percentage during each period of the program.

First Six Month Period: Enter an "x" in the appropriate box during the first six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

Second Six Month Period: Enter an "x" in the appropriate box during the second six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

Work Objective #: Enter the Work Objective number.

Target Date: Enter the consumer's projected target date for completion of objectives.

IPP Objective #: Enter the objective number from consumer's IPP (Individual Program Plan). Enter the objective title in the box after the IPP Objective #.

Behavior or *Other Work-Related:* Enter an "x" in the appropriate box if the objective is based on the consumer's behavior or other work-related issues.

Goal: State the goal of the objective.

Measurement: State what method the vendor will utilize to determine the consumer's progress.

Services for Objective: State the services that will be provided to meet the objective's goal.

Person Responsible: Provide the name(s) of the staff responsible for the objective services.

Current Functioning: State the consumer's current skill level related to the objective.

Consumer Signature: Have the consumer sign on this line.

Date: Enter the date the consumer signed the form. Enter date as mm/dd/yy.

Conservator Signature: Have the conservator or designated representative sign on this line.

Date: Enter the date the conservator or designated representative signed the form. Enter date as mm/dd/yy.

Program Staff Signature: Have the program staff person sign on this line.

Date: Enter the date the program staff person signed the form. Enter date as mm/dd/yy.

Continuation sheet (Additional objectives progress: Complete an additional worksheet for each objective as necessary.)

IHSP Participants: Indicate the names of the individuals who participated in the IHSP meeting.

Semi-Annual Objectives and Progress

First Six Month Period: Enter an "x" in the appropriate box during the first six month period whether the consumer met, partially met or did not meet his/her progression goals. Provide comments in the comment section on the consumer's progress.

Comments/Summary of Achievements: Provide comments on the consumer's progress. Also provide a summary of any achievements accomplished by the consumer.

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Person Responsible: Provide the name(s) of the staff responsible for the objective services.

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NOTICE

Read the notice and use the information to safeguard the consumer's information in accordance with the Health Insurance Portability and Accountability Act (45 C.F.R Parts 160, 162 and 164).

Month Designations:							
January	JA	April	AP	July	JL	October	OC
February	FE	May	MY	August	AG	November	NO
March	MR	June	JN	September	SE	December	DE

Regional Center ID #:		
360	FDLRC	Frank D. Lanterman Regional Center
361	GGRC	Golden Gate Regional Center
362	SDRC	San Diego Regional Center
363	FNRC	Far Northern Regional Center
364	ACRC	Alta California Regional Center
365	SARC	San Andreas Regional Center
366	TCRC	Tri-Counties Regional Center
367	CVRC	Central Valley Regional Center
368	RCOC	Regional Center of Orange County
369	IRC	Inland Regional Center
370	RCRC	Redwood Coast Regional Center
371	NBRC	North Bay Regional Center
372	KRC	Kern Regional Center
373	ELARC	East Los Angeles Regional Center
374	SCLARC	South Central Los Angeles Regional Center
375	HRC	Harbor Regional Center
376	WRC	Westside Regional Center
377	VMRC	Valley Mountain Regional Center
378	NLACRC	North Los Angeles County Regional Center
379	SGPRC	San Gabriel/Pomona Regional Center
380	RCEB	Regional Center of the East Bay

DOR Vocational Rehabilitation (VR) ID #:		
2218	VR	DOR Vocational Rehabilitation